VERMONT
DIVISION OF MENTAL HEALTH

Mental Health Block Grant Monitoring Report
July 18-21, 2006

EXECUTIVE SUMMARY

Vermont continues to make progress in the development of its mental health systems for adults with serious mental illness (SMI) and for children and adolescents who are experiencing serious emotional disturbance (SED). The State is committed to implementing evidence-based practices (EBPs) and is making other efforts to transform the systems. The adult system is incorporating principles of recovery, and the children's system is increasingly implementing local systems of care.

The mental health authority in Vermont is the Division of Mental Health (DMH), which contracts with community providers of mental health services for adults with SMI and for children and adolescents who are experiencing SED. The public mental health system has 10 Commissioner-designated nonprofit agencies located in all major geographical areas of Vermont. An additional specialized services agency, also Commissioner-designated, is a statewide resource for children with SED.

Vermont provides five of the six recognized adult EBPs in Assertive Community Treatment, Family Psychoeducation, Illness Management and Recovery, Integrated Dual Diagnosis Treatment (IDDT), and Supported Employment. Dialectical Behavioral Therapy (DBT) has also been implemented in all parts of the State. For youth, Vermont has demonstrated the effectiveness of respite, therapeutic foster care, and therapeutic family case management.

Another aspect of system transformation in Vermont is the merging of DMH with the Vermont Department of Health (VDH) to promote integration, incorporate public health approaches, promote wellness, focus on prevention and early intervention, address the impact of trauma and domestic violence, and further public education regarding mental illness.

The DMH supports effective consumer and family organizations. The Division contracts with Vermont Psychiatric Survivors to solicit input from consumers regarding adult system policies and services, to enhance the role of consumers in policy development, and to support the development of local consumer self-help groups and consumer-operated services. The DMH also contracts with the National Alliance for Mental Illness of Vermont (NAMI—VT) for many of the same reasons with respect to families of adults with severe mental illness. The DMH supports family involvement in the children's system through consistent support of the Vermont Federation of Families for Children's Mental Health. This support has created a network of family support statewide. Peer Navigators funded by this partnership are effective. The Division also supports State and local Adult and Children's Standing Committees to further promote and ensure consumer and family voice at all levels of the system of care.

The DMH has initiated other mechanisms that further system transformation. Utilizing performance indicators, the Clinical Practices Advisory Panel has been instrumental in the development and implementation of EBPs throughout the State. The Vermont Mental Health Futures Project (a planning process) and the State's compliance monitoring and quality

improvement processes have been used to address the quality and appropriateness of care as well as to provide system leadership and oversight.

ACT 264, the legislation that governs children's mental health services in Vermont, was written 18 years ago. This forward-looking legislation has guided the system-of-care development by creating a framework for family involvement and system planning.

Another aspect of Vermont's system that supports innovation and transformation is the high degree of interagency partnership that is evident. The DMH and other system stakeholders have sought various means of support, in addition to Federal grants, to improve the service system. Partnering agencies have also been willing to share their resources in innovative ways while keeping track of the funds to assure that categorical funding requirements are met.

The DMH staff and other system stakeholders acknowledge that there are many aspects of the system that need improvement. Although some aspects of the current reorganization have been positive, there is concern about whether the adoption of a chronic disease model will be effective as an approach to treating mental illness. The Global Commitment to Health (GCH) is another initiative that potentially will improve the system. This broad healthcare initiative may provide an opportunity for efficiency by reducing the volume of paperwork necessary in a fee-for-service system. There is, however, concern about whether youth with intensive needs will continue to receive the level of services currently provided under the GCH funding caps.

One significant issue that has been identified is the staff turnover rate at community mental health centers (CMHCs). In part due to this turnover, there is variability in the children's system-of-care development across the State. Flexibility at the local level furthers this variability. The DMH children's staff are also not satisfied with the level of family involvement in some areas of the State. This variability is less pronounced in the adult services system. The monitoring team recommends that the Mental Health Planning Council engage in cross-system planning to address this issue. One promising area for such planning would be to address the needs of transitional-age youth.

One area in which there has not been sufficient collaboration has been in the development and implementation of IDDT. The reorganization with the VDH, where Alcohol and Substance Abuse Services are located, and the new Co-occurring State Incentive Grant will provide opportunities and resources for an improved partnership.

Another challenge relates to the validity and reliability of service data reported by community agencies to DMH, and the relevance of some standard reports to the monitoring need of the Business Office. These issues are currently being addressed and a satisfactory solution is anticipated.

The local program visited was Washington County Mental Health Services, Inc. (WCMHS), one of 10 comprehensive CMHCs designated by Vermont statute to provide a range of services for adults with mental illness, children and adolescents with SED, and individuals with developmental disabilities. The WCMHS also provides outpatient and outreach services for

adults and children with less-severe mental health needs. The agency provides inpatient and outpatient services, case management, rehabilitation, and residential programs for adults. Individual, group, and family therapy and specialized intensive programs are provided to children and young adults and their families. The WCMHS also provides 24-hour emergency service.

The WCMHS has a focus on system transformation similar to DMH and has been a partner with DMH in demonstrating the effectiveness of the agency's respite, therapeutic foster care, and therapeutic family case management services. The Center also provides DBT. The WCMHS's adult services are comprehensive, community based, and recovery oriented. Many are provided collaboratively with other agencies and with other WCMHS programs and service components. The focus is consistently on enhancing access and supports.

The Center also has a strong commitment to the principles of the State's family-centered Act 264 legislation. Children's staff have shown leadership in developing partnerships with other child-serving agencies and in creating effective blended-funding mechanisms that support integrated services.

The WCMHS has recovered from a relatively weak financial position in FY 2003, partly due to an improved management information system. The agency's audit report cited the agency's achievement in having low accounts receivable days, aging of accounts, and lower personnel costs and occupancy costs.

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CHAPTER I: INTRODUCTION

Mental Health Services Block Grant Monitoring

The passage of Public Law (P.L.) 102-321 afforded States the opportunity to receive Federal grants for the purpose of establishing or expanding comprehensive community mental health services to adults with serious mental illness (SMI) and children with serious emotional disturbance (SED). Under the statute, each State must submit a State Plan for Comprehensive Community Mental Health Services for the fiscal year involved. Each Federal grant can be used for the purpose of planning, administration, education, and evaluation activities related to carrying out and providing services under the State Plan.

The State Planning and Systems Development Branch, Division of State and Community Systems Development, within the Center for Mental Health Services (CMHS), is organizationally responsible for ensuring each State's compliance with the array of administrative and programmatic requirements under the law. P.L. 102-321, and as amended by P.L. 106-310, requires that "the Secretary [of DHHS] shall in fiscal year 1994 and each subsequent fiscal year, conduct not less than 10 State investigations of the expenditures of grants received by the States under section 1911 . . . in order to evaluate compliance with the agreements required under the program involved" (Subpart III, Section 1945 (g)). The CMHS conducts these investigations in partnership with the States under the term "monitoring visit" to:

- Monitor the expenditures of Federal Block Grant funds;
- Assess compliance with the funding agreements and assurances required under the program;
- Identify strengths (e.g., best practices, exemplary efforts) of the State and local mental health systems; and
- Focus on opportunities for improvement, i.e., ascertain/recommend priority needs for technical assistance, identify issues that need to be addressed, as well as policy challenges related to the mental health program and service delivery at the State and local levels.

The Monitoring Visit Process

The CMHS conducts the monitoring visits with the assistance of a team of three consultants with fiscal, management, and/or clinical expertise in providing services to adults with SMI and children with SED. One member of the team is designated as the Team Leader/Writer. A Federal Project Officer makes the final selection of the members and accompanies the team. The onsite visit of the State mental health system is usually 3 days in duration. The monitoring visit includes an assessment of the State Mental Health Agency, along with interviews with Mental Health Planning Council members, consumers, and family members, and a visit to a local

program (urban, rural, or suburban) that serves adults with SMI and/or children with SED and receives some portion of Federal Block Grant funds.

In addition to monitoring the Block Grant expenditures and compliance with the funding agreements and assurances, the monitoring process involves the assessment and analysis of a range of planning, management, clinical, and fiscal issues as they relate to the implementation of the five criteria. Guidelines have been developed to assist each consultant in reviewing related materials and in conducting focused interviews to obtain necessary information to prepare the report.

Before the monitoring visit, the State Mental Health Director and the Block Grant liaison receive notification of the visit. The liaison is also contacted to:

- Discuss the purpose of the monitoring visit;
- Identify materials to be reviewed before and during the monitoring visit;
- Request the selection of a local program to be visited by the monitoring team;
- Assist in identifying key personnel to be interviewed by the consultants; and
- Develop the monitoring schedule.

General Limitations

The fiscal observations contained in this report do not constitute audit findings. The fiscal information included in the report is based on the data provided by the agencies visited. Although the fiscal consultant attempts to verify key information during the visit, the fiscal interview is not conducted according to generally accepted auditing standards issued by the American Institute of Certified Public Accountants or Government Auditing Standards issued by the Comptroller General of the United States. Other limitations of the monitoring report are: (1) the limited time spent onsite, (2) the process of selecting staff interviewed and the program visited, (3) the process used to collect and review documents, (4) the sampling nature of the monitoring visit, and (5) the inherent limitations and biases of the team of consultants.

Exhibit 1: Monitoring Visit Data Sheet

Agency Name:	Division of Mental Health (DMH)
Director's Name:	Paul Blake, Deputy Commissioner, Vermont Department of Health (VDH)
Local Program Visited:	Washington County Mental Health Services, Inc.
Date of Visit:	July 18-21, 2006
Team Assignments:	Mike McLaughlin, Child Monitor and Team Leader Gloria Newton-Logsdon, Adult Monitor Jim Stivers, Fiscal Monitor
Federal Project Officer:	Jim Morrow
Entrance Conference Participants:	Jim Morrow, Federal Project Officer Mike McLaughlin, Child Monitor Jim Stivers, Fiscal Monitor Gloria Logsdon, Adult Monitor Melinda Murtaugh, Block Grant Planner Heidi Hall, Assistant Director of Finance, VDH Dawn Philibert, Mental Health System Development Director Frank Reed, Director, Adult Mental Health Patrick Burke, Vermont Federal Programs Administration Charlie Biss, VDH DMH Children
Exit Conference Participants:	Jim Morrow, Federal Project Officer Mike McLaughlin, Child Monitor Jim Stivers, Fiscal Monitor Gloria Logsdon, Adult Monitor Paul Blake, Deputy Commissioner Charlie Biss, VDH DMH Children Frank Reed, Director, Adult Mental Health Melinda Murtaugh, Block Grant Planner Alice Maynard, DMH Children Olivia Hunter, Research and Statistics, VDH Patrick Burke, Vermont Federal Programs Administration

CHAPTER II: STATE AGENCY SERVICE AND SYSTEM ASSESSMENT

STATE SYSTEM SNAPSHOT

State Mental Health Agency and Administration of Mental Health Services

The mental health authority in Vermont is the Division of Mental Health (DMH), which contracts with community providers of mental health services for adults with severe mental illness (SMI) and for children and adolescents who are experiencing serious emotional disturbance (SED). The public mental health system has 10 Commissioner-designated nonprofit agencies (DAs) located in all major geographical areas of Vermont. An additional specialized services agency, also Commissioner-designated, is a statewide resource for children with SED.

The context in which mental health services are provided in Vermont underwent a significant change in FY 2004. The Vermont General Assembly mandated a reorganization of State government effective July 1, 2004, which moved the mental health program from the Department of Developmental and Mental Health Services to VDH within the Agency of Human Services (AHS). The AHS is composed of four departments and one office. The Office of Vermont Health Access (OVHA) manages the State's Medicaid program. The location of OVHA within the umbrella agency, AHS, facilitates a closer working relationship with the VDH and DMH.

The DMH central office staff provide leadership and direction for the community-based public mental-health system; they also provide program and service monitoring and assessment to assure adherence to State and Federal regulations and to manage the quality of services and supports delivered by DAs. The Division operates the Vermont State Hospital (VSH), Vermont's only public psychiatric hospital. Inpatient psychiatric services at VSH are the only services that DMH provides directly. Additionally, the Division contracts with five designated hospitals (DHs) for emergency inpatient psychiatric assessment and treatment of adults in need of acute hospitalization. The DHs also provide voluntary inpatient psychiatric services and limited partial hospitalization.

Mental Health Transformation

The DMH is committed to providing evidence-based practices (EBPs), emerging best practices, and values-based practices as part of its ongoing effort to transform Vermont's mental health system. Currently, a number of EBPs are present or in various stages of development and implementation throughout the State. In addition, a Clinical Practices Advisory Panel, consisting of clinicians, consumers, family members, and administrators, was developed through a partnership among DMH, providers, consumers, and family members. The goal is to devise a multistakeholder consensus process to make decisions regarding the effectiveness of evolving practices in the Vermont mental health system.

The DMH also has an opportunity with the Division's move to Burlington to utilize its relationship with the psychiatry department of the University of Vermont (UVM). In particular, the Child Behavior Checklist developed at UVM will be used to identify effective outcomes for intensive residential and wraparound waiver services. The process will replicate the effort used in Vermont's Robert Wood Johnson grant that demonstrated the effectiveness of therapeutic foster care and therapeutic family case management. The DMH is also providing training to mental health centers in quality improvement and co-occurring treatment and has initiated a statewide trauma workgroup. In addition, the Division has established several research projects. These projects focus on attention deficit hyperactivity disorder, evaluation of a pediatric partnership initiative, and evaluation of a psychiatric consultation initiative. The parent agency, the VDH, is also working with the UVM medical school, particularly with the Director of Public Health Nursing, to integrate mental health services.

Moreover, DMH funding is used to support training of provider staff, consumers, and family members in the areas of family education provided by the National Alliance for Mental Illness—VT (NAMI—VT) and statewide recovery education courses administered and conducted by Vermont Psychiatric Survivors (VPS) to assist consumers in developing skills and coping strategies so they can have independent, fulfilling lives. In addition, workforce development to facilitate and support transformation of the State mental health system not described elsewhere in this report includes Integrated Dual Diagnosis Treatment (IDDT) training workshops and agency-specific consultation for IDDT providers, as well as supported employment (SE) training and consultation on using SE to increase employment opportunities for consumers.

Other mental health system transformation developments include DMH becoming part of VDH in 2004. According to the 2005 Vermont Mental Health Block Grant (MHBG) Application, DMH's placement in VDH facilitates and supports transformation by:

- Eliminating the conceptual split between mind and body;
- Promoting a wider public perception of mental health as essential to overall health, thus increasing understanding of mental illness and reducing stigma;
- Enhancing opportunities for VDH's Divisions of Public Health, Alcohol and Drug Abuse Services, and Mental Health to collaborate more effectively in making coordinated and/or integrated services accessible in a continuum of healthcare;
- Focusing on the wellness of entire communities, not simply target groups;
- Increasing appreciation of the impact of trauma and domestic violence on the health of individuals;
- Increasing the focus on prevention and early intervention to reduce illness and disability; and

- Orienting the mental health system toward more scientific rigor in assessing the efficacy of services and supports.

The DMH is adopting a public health model for children's mental health. The basic belief is that all youth need socioemotional skills for healthy functioning. The DMH is identifying risk and protective factors in socioemotional development, such as poverty as a risk factor and having a consistent parenting figure as a protective factor.

Issues, Trends, and Challenges

The VSH, the State's only public psychiatric hospital, was decertified in 2003 and again in 2005 after being recertified for a few months. These events led to the redeployment of four senior DMH Adult Unit managers to plan and implement extensive corrective actions at VSH. Some of the factors leading to an intensive strategic planning process for future inpatient services in the Vermont mental health system were: the age of the building and expense associated with renovating VSH, the elimination of Medicaid payments for Institute for Mental Disease (IMD) patients, the decision to reconfigure best practices for intensive inpatient care for the most-difficult-to-serve adults within a broad continuum of mental health services statewide, and legislation requiring the planning. A Vermont Mental Health Futures Advisory Committee has guided the development of a plan that includes the relocation of inpatient services to other sites as well as the following community-based components: secure residential capacity, subacute rehabilitation capacity, and a statewide system-of-care management to coordinate the levels of care.

The major recent issue facing DMH has been the Agency of Human Services (AHS) reorganization, which resulted in the Division merging into the VDH. The goal is to move toward integration with healthcare, substance abuse prevention, and training.

A major initiative in the public healthcare system in Vermont is the Global Commitment to Health (GCH). This is a Medicaid 1115 Demonstration Waiver that builds on previous 1115 waivers, called Dr. Dynasaur (an intentional misspelling), Vermont Health Access Plan (VHAP), and Healthy Vermonters. The intent of the waiver is to manage Medicaid services to prevent a projected deficit. The GCH will pay a managed-care organization (MCO) a capitated premium payment to manage the Medicaid healthcare system. This waiver also allows for greater flexibility in program design and operations. The DMH sees GCH as an opportunity for efficiency and innovation, such as reducing the volume of paperwork necessary in a fee-for-service system.

In children's services, the reorganization impacted the early childhood system of care. The program, called Children's Upstream Services (CUPS), was moved into the early childhood division of the Department for Children and Families (DCF). The DMH is targeting transitional-aged youth for system-of-care development in 2008. The goal of this effort will be to provide services and supports, such as housing, to youth currently in foster care. Many of these youth do not have a severe, disabling mental illness and will not be eligible for services as adults.

Planning Process and the Mental Health Planning Council

Act 264, the legislation that governs children's mental health services in Vermont, requires a 5-year coordinated children's system-of-care plan with yearly updates. Vermont's *Administrative Rules on Agency Designation* mandate statewide and local Standing Committees for adult mental health and for children and adolescents experiencing a serious emotional disturbance and their families. In addition to participating in the system-of-care planning process, the Children's Standing Committee completes a yearly report of needs and goals.

The Mental Health Planning Council (MHPC) meets twice a year to review and evaluate the MHBG. Members of the MHPC, in a sub-group of the Standing Committees, perform the three functions required in the Mental Health Block Grant legislation. Members of both these Committees indicated that they advocate and that they participate in the evaluation of both the children's and adult mental health systems. The DMH *Administrative Rules* require members of Standing Committees to participate in program reviews of intensive, therapeutic, family support, and prevention/consultation/education services and other programs at designated agencies.

The MHPC members indicated that regional flexibility is both a strength and a weakness in Vermont. They believe there needs to be greater consistency across the State. There has been some degree of improved accountability. For example, the problem of the shackling of youth being transported to residential facilities was addressed this past year.

The MHPC members understand and support the goals of the recent reorganization, and they believe there have been concrete changes. One positive change is the training for staff and contractors of AHS. This training focuses on four areas, including strength-based relationships, holistic practice, outcomes, and excellent customer service. It was noted that staff job descriptions have changed and there is more accountability. The field directors added in the reorganization are seen as helpful. The New Agency Team is also seen as effective.

A Planning Council member expressed a desire for better communication within the children's system, indicating that there is variability in local Standing Committees in terms of family involvement and followthrough. Because of this, many members of both the local and statewide Children's Standing Committees do not stay. This individual also believes that there is a need to move from a State structure to a family structure. She indicated that she believes the reorganization presents an opportunity to achieve these goals. Another member reported that her region is much more proactive than others.

Exhibit 2: Planning Council Composition by Type of Member

Type of Membership	Number	Percentage of Total Membership
TOTAL MEMBERSHIP	**30**	
Consumers/Survivors/Ex-patients (C/S/X)	7	
Family Members of Children Diagnosed with SED	4	
Family Members of Adults Diagnosed with SMI	3	
Vacancies (C/S/X and family members)	0	
Others (not State employees or providers)	2	
TOTAL C/S/X, Family Members, and Others	**16**	**52**
State Employees	6	
Providers	7	
Vacancies	2	
TOTAL State Employees and Providers	**15**	**48**

Management Information Systems (MIS)

Vermont's Management Information System (MIS) for health-related services is known as the Managed Care Information System (MCIS). Within that system, the Mental Health Research and Statistics Office focuses on mental-health-related client services and demographic data. This office focuses exclusively on mental health and substance abuse data and produces regular and ad hoc reports for use by DMH staff and other related parties. Data produced by the Mental Health Research and Statistics Office are categorized into four groups. Those groups are data about clients, services, fiscal issues, and staffing.

Mental health staff working with the MCIS data system are satisfied with the current system in terms of hardware and software capabilities. They believe the current system will meet their data needs over the next 10 years without modifications. They also believe that the current system produces the reports needed to manage their system. The system is capable of accessing the State's Medicaid data component, and DMH staff can generate reports from that system for evaluating community provider Medicaid earnings and other Medicaid-related inquiries.

Both fiscal and client-services data are available to DMH program managers for purposes of planning, accountability, and decisionmaking. Data management staff ensure that program managers are aware of the system's capability in these areas. Routine reports and special inquiry reports are available on a regular basis for all system participants. The DMH data staff disseminate these reports to more than 300 users, including the DAs providing community mental health services. Data staff contend that the DAs respond to the information provided them better than any other element of the system.

The system examines data on a catchment-area basis as well as on a statewide basis. Service-related data based on demographic characteristics are the most used area of information.

Performance indicator reports are available on a weekly basis, whereas some other reports are available on a monthly or annual basis. For example, hospital inpatient reports are produced annually, and client employment reports are produced monthly. These reports are important to fiscal managers and program administrators in making programmatic and funding decisions.

The MCIS data system produces regular monthly and annual reports on clients served and services provided. The following table provides some context in terms of the DMH system's client caseload served by the 10 DAs and other community entities.

Table 1: Client Services Reported by MCIS

Year	Adults	Children	Sub Abuse	Inpatient	Unassigned
FY 2004	10,325	10,040	5,101	231	2.396
FY 2005	10,081	10,122	4,495	218	2.898

Source: VDH Statistical Reports, FY 2004 and FY 2005.

Information is generated by the MCIS system for reporting on Federal Block Grant implementation from reports on eligible client services and demographic characteristics that identify Block-Grant-eligible client groups. Client services reports are analyzed and correlated with fiscal and contract information to ensure compliance with Block Grant requirements.

The MCIS staff do not identify any issues or concerns related to the implementation of the Health Insurance Portability and Accountability Act (HIPAA) or Decision Support 2000+. Staff are familiar with HIPAA requirements and state that they do not publish any data that would conflict with HIPAA regulations. The system is not currently using Decision Support 2000+ because staff contend they have not found it useful and are unable to download necessary tables.

Compliance Monitoring and Quality Improvement

Vermont employs a number of quality management processes, including Agency Designation, which is a comprehensive review every 4 years of program, fiscal, and management operations for the State's 10 full-service and 1 specialized-service agencies. The agency designation process uses standards promulgated in regulations to assess financial and clinical records. As part of the agency designation process, interviews and surveys are conducted and outcome information analyzed.

There are also annual designation reviews for general hospital psychiatric units, quarterly audits of involuntary treatment admissions in general hospitals, and prior authorization and clinical continued-stay reviews for every Community Rehabilitation and Treatment (CRT) inpatient and Medicaid children's mental health admission. Consumer and Family Satisfaction Surveys, grievances and appeals, critical incident reporting guidelines, transportation tracking for involuntary admissions, and guidelines for core capacity services are some of the other compliance monitoring and quality improvement processes used by the State. In addition, six of the designated nonprofit agencies (DAs) have Commission on Accreditation of Rehabilitation

Facilities (CARF) or Joint Commission on Accreditation of Health Care Organizations (JCAHO) accreditation.

Within adult services, there are minimum standards for the review of clinical records every 2 years, treatment guidelines, the VSH Treatment Review Panel, and Preadmission Screening and Annual Resident Review (PASARR) oversight. Processes used by the Child, Adolescent, and Family Unit (CAFU) include the following: technical assistance and direct consultation with DAs and interagency treatment teams to assure appropriate, high-quality care for youth with intense, complex needs; a Child Behavior Checklist data review on progress/outcomes for all intensive-needs youth funded through the waiver; and Individualized Service Budgets for youth in residential placement.

Consumer and Family Member Involvement

The State's "Administrative Rules on Agency Designation" requires State and Local Program Standing Committees for each population served. The mental health system has an Adult State Program Standing Committee (SPSC) and a Children's SPSC. Members are appointed to staggered 3-year terms by the Governor, and a majority of the Committee must be disclosed consumers and family members of individuals served. The State Committees are an integral part of the State MHPC and advise the Commissioner regarding the appointment of new division and unit directors. Other responsibilities are to review information and provide advice regarding the quality and responsiveness of statewide services and the State System-of-Care Plan; Division policy, complaints, grievances, and appeals; and the process for agency initial designation and redesignation.

The Local Program Standing Committees (LPSCs) have comparable responsibilities at the DA level. They review and recommend policies that pertain to or significantly influence services for the population they represent and set policy when delegated the authority by the DA Board of Directors. As part of the designation process, DAs must demonstrate recognition of the importance of consumer involvement by obtaining and monitoring consumer satisfaction, documenting the use of the information through quality improvement processes, and documenting consumer/family inclusion in program design. In addition, consumer/family inclusion in the agency designation and redesignation process is required. Moreover, regulation requires consumer/family inclusion in reviews of service quality monitoring and evaluation and program effectiveness, as well as in the design, delivery, and evaluation of training.

During State Fiscal Year (SFY) 2005, VDH/DMH used State, MHBG, and Real Choice Grant funding to contract with VPS to fund the 14th year of operation of the statewide consumer/ex-patient organization. Contract deliverables included the following:

- Developing, promoting and assisting local mental health consumer/ex-patient support groups and activities throughout the State;

- Staffing a statewide 800 telephone information, referral, and emotional support line;

- Publishing a quarterly newsletter;
- Assisting community mental health centers (CMHCs) in recruiting consumers for LPSCs and in the development and effective functioning of the committees;
- Coordinating and expanding the Recovery Education Project at all 10 CMHCs;
- Providing staff supervision and administrative support, in conjunction with the Clara Martin Center, to the Safe Haven Residential Program;
- Making administrative improvements;
- Convening an annual meeting;
- Designating representatives to attend relevant State committees and task forces; and
- Submitting quarterly reports to the State.

There are four peer-operated programs in Vermont. These services include an antistigma and outreach program, the Mental Health Education Initiative, a peer-run warm line, and a recovery drop-in center.

The DMH children's services staff are not satisfied with the level of family involvement in the system. They noted that, to some degree, the success of outreach and family-centered services creates conditions that make parent involvement more difficult, because families do not associate with office or program settings. One Standing Committee has a virtual committee approach, using Internet technology for real-time involvement.

Parent advocates indicated that there has been significant progress in recent years. The DMH contracts with the Federation of Families to provide Peer Navigators, who help find resources, provide support at meetings, and identify service gaps.

Consumer and Family Rights

The State's process for assuring consumer/family rights is delineated in section 4.13 of "Administrative Rules on Agency Designation." The DAs are required to have a written policy which assures that the rights of individuals receiving mental health services are consistent with Act 264 for youth with SED and Division CRT Guidelines for adults with SMI. At least annually, agencies are mandated to post the list of patient rights and responsibilities and to inform individuals served of the rights and responsibilities specified in section 4.13.1 through 4.13.9, as well as of other rights and responsibilities.

ADULT MENTAL HEALTH SERVICES

Target Population and Service Array for Adults

The Division's Adult Unit is responsible for overseeing the provision of services to individuals with SMI who are 18 years of age and older. Adults with SMI who meet the State diagnostic, functional, and service utilization criteria are eligible for enrollment in CRT programs that served approximately 3,200 adults in SFY 2005.

The DMH also provides limited funding for DAs to serve adults who do not meet CRT eligibility criteria but who can benefit from mental health services. The agencies are located in all major geographical areas of the State, and a number of DAs have more than one office in their service area. These adult outpatient programs (AOPs) served approximately 7,000 individuals in SFY 2005, and the range of services varies from DA to DA.

An estimated 6,000 to 7,000 adults and children received emergency mental health services, which are provided to individuals in mental-health crisis 7 days a week, 24 hours a day. Services include emergency/crisis assessment, support, referral, and emergency crisis beds for short-term 24-hour residential supports in settings other than the person's home. In addition to emergency services for individuals, there are emergency services programs for communities or staff of organizations coping with traumatic or tragic events, such as natural disasters, homicides, suicides, or terrorist attacks.

The VSH offers a level of inpatient care that cannot be provided by the five DHs with which DMH contracts for emergency adult inpatient psychiatric assessment and acute inpatient treatment, voluntary inpatient treatment, and limited partial hospitalization. During SFY 2005, 492 CRT clients received inpatient care. Sixty-eight were admitted to VSH, and the other 424 were admitted to DHs and one out-of-State hospital. Of the 200 admissions to VSH in SFY 2005, 99 were court-ordered psychiatric examinations for defendants in criminal cases. These admissions account for 9,120 of the total of 19,159 VHS patient days for that period. The average daily census for VSH in SFY 2005 was 46. Moreover, during SFY 2005, the community services budget for adults was more than twice the budget for inpatient care at both VSH and DHs.

Community services for adults with severe mental illness include the following:

- Service planning and coordination (case management);
- Community supports;
- Employment services;
- Clinical interventions;
- Consultation, education, and advocacy;
- Crisis services;
- Housing and home supports;
- Transportation;
- Partial hospitalization;
- Day services;

- Substance abuse services;
- Medical and dental services; and
- Services for persons with co-occurring disorders of mental illness and substance abuse.

Case management and other community supports assist consumers in obtaining and maintaining housing and employment as well as avoiding rehospitalization. In Vermont, case management includes activities to assist individuals and their families in planning, developing, choosing, gaining access to, coordinating, and monitoring the provision of needed services and supports. These services and supports may be formal or informal and include discharge planning and advocacy, as well as monitoring the well-being of consumers and their families. Ninety-five percent of Vermont's Medicaid-eligible CRT clients receive case management services.

The EBPs available in Vermont are Assertive Community Treatment (ACT), Family Psychoeducation (FPE), Illness Management and Recovery (IMR), IDDT, and SE. During SFY 2005, 360 adults with SMI were served by ACT, 260 by FPE, 230 by IMR, 600 by IDDT, and 800 to 900 by SE. In addition, 2,400 consumers with SMI received supported housing services. Dialectical Behavioral Therapy (DBT) is also provided in nine of the State's catchment areas. In addition, Vermont applied for, but did not receive, a grant to pilot implementation of Medication Algorithms.

In SFY 2005, wages were reported to the Vermont Department of Employment and Training for 850 to 900 CRT consumers, which represented 25 to 30 percent of all individuals served in CRT programs. For DMH, increasing employment is one of its top priorities for CRT clients, and encouraging consumers and providing them with employment opportunities of their choice is a service system value. The SE services with high fidelity ratings for adults with SMI are available in all 10 of the State's catchment areas.

During SFY 2005, DMH also implemented the statewide IDDT EBP project, with full review across its 10 DAs. The project includes a large and sustained statewide training and implementation initiative in all 10 CRT programs as well as in other mental health and substance abuse programs. Currently, most CRT programs provide at least some integrated services, and a new Center for Mental Health Services (CMHS) Co-occurring State Incentive Grant (COSIG) is funding the expansion of IDDT into AOP.

The DMH is working with the Department of Disabilities, Aging, and Independent Living on the ElderCare Initiative. Five hundred older adults are served in programs jointly administered by the DAs and Area Offices on Aging. Services are partially funded with a $250,000 allocation for the initiative and include geriatric and psychiatric consultation, counseling, home visits, and community outreach. Staff acknowledged the importance of documenting the unmet needs of this underserved population to enhance service capacity and access.

Availability and Accessibility

Vermont has indicators for mental health program performance that are a product of the CMHS-funded Mental Health Performance Indicator Project and that were developed by the project's

multistakeholder advisory group. There are indicators of treatment outcomes, access to care, and services provided/received based on geography and urgency. The State's "Administrative Rules on Agency Designation" requires the DAs to provide interpreter services and access for individuals with physical disabilities and to address adaptive equipment needs. There is an agency-level cultural competency plan and training program and a VDH Cultural Competency Director. The State is 97 percent Caucasian and 1 percent Hispanic. French-Canadians and individuals from Vietnam, Bosnia, and Somalia also live in some areas of the State.

Vermont is one of the country's most rural States, with 70 percent of its population living in towns and villages with fewer than 2,000 inhabitants. It has 1 Metropolitan Statistical Area (MSA) and 7 cities with more than 10,000 inhabitants. Twenty-five percent of Vermonters live in small communities, 25 percent in the Burlington MSA, and the other 50 percent in communities of 2,000 to 20,000 individuals.

Thus the service delivery system must provide both outreach to sparsely populated remote areas and mechanisms for bringing individuals to service locations. A number of CMHCs have more than one office, and transportation is a core DA service. These agencies have their own buses or contract for bus service. In addition, outreach-oriented case management and emergency services facilitate service access. Staff are mobile and provide services, including crisis outreach, in other than DA office locations. The goal is to make services accessible to all individuals served by the public mental health system whether they live in urban or rural areas or are homeless.

Coordination and Continuity

Two DAs have Johnson and Johnson funding for SE, and, although another agency's funding has ended, that agency will still participate in data collection for the project. Two additional DAs have Medicaid Infrastructure Grants to promote relationships with employers and improve employment outcomes. Moreover, during the monitoring visit, it was apparent that in Vermont good communication and collaboration exist between DMH and the Division of Vocational Rehabilitation to promote, fund, and provide technical assistance to evidence-based SE.

The Division has initiated yearlong followup monitoring of all VSH discharges as well as of adults on orders of nonhospitalization (community commitments). In addition, the Acute Care Management (ACM) system is responsible for working with DAs regarding joint utilization review and management of inpatient hospitalization of children and CRT adult consumers whose primary pay source is Medicaid. The ACM system also assists with discharge planning and coordination of multiple agencies involved in aftercare.

Monitoring medical and dental services for CRT consumers occurs at the local level. Annual physical examinations and other medical issues are addressed, and case managers assist consumers in keeping appointments with physicians, dentists, and other healthcare professionals. In addition, DMH administers a special-services fund to help consumers with dental expenses not covered by other payers.

Outreach to the Homeless

The Division has Project to Assist in the Transition from Homelessness (PATH) contracts with seven local providers for services to individuals with SMI or a dual diagnosis who are homeless or at risk of homelessness. The focus is on providing outreach and case management in the eight catchment areas of the State where PATH services are provided. In these areas, the project staff work closely with State and local public housing authorities, the statewide continuum of care, landlords, nonprofit housing developers, and DA housing staff to obtain rental assistance and decent housing for the target population. Other services coordinated within the projects include health, mental health, and substance abuse services; law enforcement, income maintenance, and entitlements; and services offered by charitable and religious groups and other community organizations concerned with homelessness. In addition, DA housing contingency funds supplement partial rent payments while consumers are on waiting lists for Public Housing Authority housing subsidies. According to DMH, Vermont is the only State where all PATH providers can access the Homeless Management Information System (HMIS).

CHILDREN'S MENTAL HEALTH SERVICES

The DMH's CAFU is responsible for seeing that mental health services are provided to children and adolescents under the age of 18 and their families. Mental health services in the community are often delivered as components of a broad continuum of care that includes services from other AHS divisions.

Target Population and Service Array for Children

The target population and definition have not changed since the last monitoring visit. The range of services has expanded. Core Capacity Services are available regionally through DAs. In addition to these Core Capacity Services, intensive residential services, emergency/hospital diversion beds, and hospital inpatient services are available to the entire State of Vermont.

Core Capacity Services include the following:

- Immediate Response: Each DA provides access to an immediate response service and/or short-term intervention for children and adolescents who are experiencing a crisis and their families. Crisis services are intensive, time-limited supports (usually 2-3 days) consisting of the following elements:

    - Telephone assessment, support, and referral;
    - Crisis assessment, outreach, and stabilization;
    - Family and individual education, consultation, and training;
    - Service planning and coordination;
    - Emergency/crisis bed; and
    - Screening for inpatient psychiatric hospitalization.

- Outreach Treatment: Each DA offers a comprehensive array of outreach treatment services for children and families. These services employ best practices in outreach clinical service delivery and are available in the home, school, and general community settings. The intensity of the service is based on the clinical needs of the child and family and the family's request for one or more of the following elements:

    - Clinical assessment;
    - Group, individual, and family therapies;
    - Service planning and coordination (including residential case review);
    - Intensive in-home and out-of-home community services to the child and family (including foster and adoptive families);
    - Medication services; and
    - Family and individual education, consultation, and training.

- Clinic-Based Treatment: Each DA offers a comprehensive array of clinic-based treatment services for children and families. These services employ best practices in office-based clinical service delivery and are available during daytime and evening hours when families can easily access them. The intensity of the service is based on the clinical needs of the child and family and the family's request for one or more of the following elements:

    - Clinical assessment;
    - Group, individual, and family therapies;
    - Service planning and coordination; and
    - Medication services.

- Support: Support services can be instrumental in reducing family stress and providing parents and caregivers with the guidance, support and skills to nurture a difficult-to-care-for child. Each DA provides and/or has direct community connections to a comprehensive array of support services for families and youth. These services are offered in partnership with parents and consumer advocates and are provided as the family needs and desires:

    - Skills training and social support;
    - Peer support and advocacy;
    - Respite; and
    - Family and individual education, consultation and training.

- Prevention, Screening, Referral, and Community Consultation: Each designated agency provides and/or has direct involvement in creating and/or maintaining community

agreements that promote psychological health and resilience for families and youth. Primary prevention efforts focus on promoting healthy lifestyles and healthy communities for all youth and families. Secondary prevention efforts focus on reducing the effects of risk factors, minimizing trauma potential and maximizing resiliency potential. Tertiary prevention (i.e., treatment) efforts focus on reducing any trauma and dysfunction that may be created by a difficult event or situation. The prevention agreements may focus on one or more of the following elements:

- Work with families, community groups, schools, and healthcare and childcare providers to improve situations/environments for children and families and to provide education, consultation, and training;

- Screening and referral; and

- Educational activities about mental health for the public at large.

The intensive services available statewide include the following:

- Intensive Residential Services: The Division of Mental Health contracts with three residential treatment programs to provide intensive mental health residential treatment for children and youth in Vermont: Baird Center for Children and Families (a division of the Howard Center for Human Services), Northeastern Family Institute (NFI), and Retreat Healthcare. These programs have around-the-clock awake staff, medical/psychiatric backup services, and an in-house array of psychological assessment and treatment services.

- Emergency/Hospital Diversion Beds: Emergency or hospital diversion beds are community-based programs that provide a high level of care and have the ability to divert youth from inpatient hospitalization. Typically, youth who do not require around-the-clock medical monitoring can be stabilized in a smaller, less-institutional treatment setting. Like the Intensive Residential Services, Hospital Diversion programs have 24-hour awake night staff; 24-hour psychiatric and in-house crisis backup; and the ability to conduct psychological, neurological, and other specialized testing as needed. The typical length of stay in these services is 1 to 10 days.

- Hospital Inpatient Services: Three hospitals provide psychiatric inpatient services for Vermont youth: Champlain Valley Psychiatric Hospital in Plattsburgh, New York; Cheshire Medical Center in Keene, New Hampshire; and Retreat Healthcare in Brattleboro, Vermont. A child meeting the criteria for an emergency exam may be placed only at Retreat Healthcare. Inpatient hospitalization may be required for youth with a mental illness who:

  - Require around-the-clock medical monitoring for such things as drug overdoses, suicide attempts, or other complicating medical conditions;

- Have complex and uncontrollable behaviors, such as causing or threatening harm to themselves and/or others;

- Cannot be stabilized in a smaller and more individualized hospital diversion treatment setting; and/or

- Meet the criteria for an emergency exam.

Availability and Accessibility

The DMH places an emphasis on evaluating the effectiveness and the capacity of the system of care. There are specific goals for availability and access across the State. Analysis of these goals indicates that core services that are clearly identified are available in all areas. The Division believes that just over half of the youth with SED have been served by the public mental health system. The DMH believes there is a significant unmet need for more treatment capacity for children and their families, as well as for consultation with teachers, childcare providers, and other direct-service (including healthcare) workers.

The Division believes that the core capacities for treatment and support must be expanded with additional resources and staff for the mental health centers. The CAFU is exploring ways to help fund additional outreach services through a specific type of Medicaid funds available for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). The Division also has been exploring the possibility of multiple agencies in a community jointly purchasing psychiatric (1) supervision for DA clinical staff and (2) consultation with pediatricians. In addition, some DAs have been able to hire psychiatric nurse practitioners.

In part because DAs experience over 20-percent turnover among their children's mental health staff every year, there is an ongoing need for in-service training of staff, particularly in the following areas. The DMH believes the staff who respond to mental health emergencies should be trained to respond to child and family crises in ways that support the child and family and the community. The Division also believes that more staff should know how to design and deliver individualized services and supports in the community, especially for children with intensive needs. The Division's studies have shown that only a small percentage of the children and youth served receive intensive services in accordance with individualized service plans and budgets or waivers. Far more children and youth need these services, including those with Pervasive Developmental Disorder who have an IQ over 70, those who have been repeatedly ejected from daycare programs, those whose adoptions are at risk of failing, those with co-occurring substance abuse, and those in transition to adult services.

The DMH staff also are aware that there are increasing numbers of adolescents experiencing SED who also use alcohol or drugs; therefore, more staff in DAs should be trained in screening and prevention strategies for such use and in effective and integrated treatment methods.

The DMH staff indicate that there is a need to improve the availability of mental health services to youth with co-occurring developmental disability, youth diagnosed with disorders on the Autism Spectrum, and services to transitional-aged youth.

Despite the relatively low population of non-Caucasian residents in Vermont, there have been efforts to address cultural competency and to provide culturally sensitive services. One DA is applying for a grant to address linguistic barriers, in response to recent growth in non-English-speaking clients. The umbrella AHS has identified poverty as a cultural issue and is implementing an initiative called Bridges out of Poverty. Cultural competency training is required by the agency. There is also an Office of Minority Health in the VDH. Policy also exists to assure that services are sensitive to the needs of bisexual, gay, lesbian, and transgender youth.

Out-of-State Placement

There is a case-review process for all residential treatment, including out-of-State placements. There is currently one youth placed out of the State for mental health treatment.

Coordination and Continuity

Following a successful experience with Child and Adolescent Special Services Program funding that resulted in systematically greater flexibility in the types and funding of services, Vermont has made steady progress in developing systems of care since 1993. During that year, DMH worked collaboratively with DCF to jointly fund improved immediate-response services for youth. The DCF made invitations to communities to develop crisis services and create their view of the ideal system. The outcome sought was to reduce the number of youth in State custody. This effort was effective in reducing the rate of custody for children in need of care or supervision by 33 percent. A second System-of-Care Grant focused on youth under age 6 and targeted teen parents through partnerships with early childhood providers. More recently, the focus has been on youth over age 6. This collaboration funds school mental health services across the State, with schools providing the Federal Medicaid match. On July 1 of this year, the existing interagency agreement was further expanded. The DMH is now partnering with substance abuse, developmental services, vocational rehabilitation, and transitional service agencies. Throughout this process of developing systems of care, the child-serving agencies have committed resources and demonstrated effectiveness, so that the services and supports developed have been sustained.

In addition to the development of systems of care, Vermont has implemented a successful home- and community-based waiver. The DMH secured funding for its initiatives from various sources, including the Robert Wood Johnson Foundation.

A core component of case coordination is the coordinated service plan, which ensures access to a process that is coordinated across systems. The coordinated service plan must also address issues in the child's individualized educational plan.

The new alignment with the VDH is seen by DMH staff as an opportunity to improve the promotion of mental health and the prevention of mental health problems. A current initiative has created a pediatric collaborative that provides screening and services as needed in multiple pilot sites. Some of these sites utilize Telemedicine. Another recent initiative targets transitional-aged youth who do not readily fit into existing services. This partnership with vocational rehabilitation services, corrections, and DCF incorporates a nontraditional work program augmented by wraparound case management services.

Outreach to the Homeless

There are centers for runaway and homeless youth across the State. One specialized program, called Spectrum, is a one-stop program with a walk-in center that also provides outreach. The program also makes single-room-occupancy housing available.

FINANCIAL MANAGEMENT

Financial management of Vermont's mental health system is administered through the VDH's Business Office. The VDH consists of eight separate program divisions. Mental health and substance abuse programs are found in two Divisions, and both DMH and the Division of Alcohol and Drug Abuse Programs (ADAP) contract with nonprofit community provider agencies for the provision of community services. The VDH does not directly provide community treatment services in Vermont.

The DMH includes program staff who report to the Deputy Commissioner for Mental Health. Fiscal operations for all program divisions are concentrated within the VDH's Business Office. The Business Office's fiscal staff includes individuals who previously managed fiscal operations for mental health and substance abuse programs. This arrangement ensures the preservation of expertise and historical knowledge related to the various program areas while continuing the financial relationships and expertise already established by VDH personnel. Individuals who previously managed fiscal operations within the mental health and substance abuse programs also fill supervisory positions within the VDH's fiscal staffing structure.

The DMH contracts with 10 designated nonprofit agencies (DAs) serving the State's 14 counties for the provision of community mental health services. These DAs are nonprofit entities that make up the community mental health system in Vermont. The Division also contracts with other agencies for special needs not addressed in the DA contracts. These entities have a longstanding relationship with the Division preceding the reorganization of the State system.

Business Office staff maintain a close working relationship with administrative staff from the DAs. Staff from the VDH Business Office and the DAs meet regularly to discuss financial, administrative, and data management issues related to business operations and service delivery elements. Business Office fiscal staff contend that their close working relationship with community providers allows them to observe trends more readily and to address concerns through a spirit of mutual collaboration.

Some of the reports that DMH provides in monitoring community agencies and providing them technical assistance in the area of financial management include the following:

- Gain/Loss Summary Report;
- Revenues and Expenditures Summary Report;
- Days of Net Assets Report;
- Accounts Receivable Turnover Rate Report;
- Current Ration Analysis;
- Days of Cash Reserves Report; and
- Administrative Costs Ration Analysis.

Budgetary Planning

The DMH budget planning for the next fiscal year begins in the summer at the Division level. The process begins with the Governor making a commitment for a level of funding sufficient to meet Division needs within available revenue parameters. Division staff, community providers, and advocates have an opportunity to provide input to this process. Division staff evaluate system financial needs by program area and geographic region. Meetings are held to discuss budget issues, resulting in a draft Division budget. The DMH budget is then incorporated into the VDH budget merged with the AHS budget for submission through the Governor to the General Assembly. The Vermont Legislature meets in January, with the final budget being approved by June.

Advance estimates, based on the draft budget, are forwarded to community providers in February for their own individual agency budgetary planning. Providers are required to submit their budgets to DMH by April for development of contracts and grants to be effective by July 1 of the upcoming fiscal year.

Adjustments to an existing budget, such as requests for additional funding, are dealt with in the budget adjustment process; however, staff contend such requests are rare due to the built-in flexibility of budget appropriations and the thoroughness of the budgeting process. The current budget adjustment process allows for attention to unexpected financial issues without additional legislative approval.

The DMH staff do not anticipate any pending issues that would significantly impact future budgets for mental health services. There are no pending court cases or expected tax cuts that would reduce funding for mental health services. The State has experienced budget surpluses for the past 3 years, and the State economy is expected to remain stable throughout the foreseeable future. Current plans to replace the VSH facility will necessitate a significant capital outlay, but the State is prepared to incur this cost without affecting revenues for community mental health services.

Revenues and Expenditures for Mental Health

The following table shows Vermont mental health expenditures for a 5-year period through the current budget period.

Table 2: State and Federal Expenditures for Mental Health Programs

Category	2003	2004	2005	2006	2007
Adult Mental Health	33,111,371	36,700,786	39,746,064	43,587,562	51,007,618
Percent of total	35.8	35.3	36.4	36.2	37.5
Children's Mental Health	44,480,481	50,382,301	51,310,857	55,504,349	61,331,399
Percent of total	48.1	48.5	47.0	46.1	45.1
Total Community Mental Health	**77,591,852**	**87,083,087**	**91,056,921**	**99,091,911**	**112,339,017**
% of total	83.8	83.8	83.4	82.3	82.6
Inpatient	12,346,433	13,545,510	15,033,031	17,296,789	18,708,479
Percent of total	13.3	13.1	13.8	14.4	13.8
Administration	2,609,937	3,234,233	3,030,705	3,993,099	4,890,891
Percent of total	2.8	3.1	2.8	3.3	3.6
Total	**$92,548,222**	**$103,862,830**	**$109,120,657**	**$120,381,799**	**$135,938,387**

Sources: Vermont financial records and summary reports for FY 2003, FY 2004, FY 2005, FY 2006, and FY 2007 budget documents.

Notes:

1. FY 2006 figures represent preliminary amounts subject to yearend closing activities.

2. FY 2007 figures represent budgeted amounts for the current operating year.

3. All amounts are for purposes of comparison only.

4. The total mental health budget has increased by 46.9 percent over the 5-year period, with each category experiencing increased funding and some slight deviations in programmatic shares of the total budget.

5. Total increases for each program area are as follows:
   Adult Mental Health: 54.1 percent
   Children's Mental Health: 37.9 percent
   Inpatient: 51.5 percent

The following table shows Vermont's mental health program revenues for the 4-year period preceding the current fiscal year.

Table 3: Revenue Sources for Vermont Mental Health Programs

Category	FY 2003	FY 2004	FY 2005	FY 2006
State General Funds	27,830,350	30,193,911	39,964,743	21,965,626
Special Funds	7,337,428	8,927,395	9,758,068	2,554,294
Inter-Department Transfers	3,015,965	3,952,086	18,595,565	1,252,676
Total State Funds	**38,183,743**	**43,073,392**	**68,318,376**	**25,772,596**
Federal Funds	56,195,446	60,789,375	54,377,744	17,167,159
Global Commitment Funds				77,596,721
Total Funding	**$94,379,189**	**$103,862,767**	**$122,696,120**	**$120,536,476**

Source: Vermont DMH financial records and summary documents for FY 2003, FY 2004, FY 2005, and FY 2006.

Notes:

1. Vermont uses a blended-funding approach to children's mental health services wherein State funds from the State's educational system and child welfare system are transferred to DMH for expanded services.

2. In FY 2006, Vermont's Global Commitment program (Medicaid Waiver) combined State and Federal funding to support community-based mental health services.

Based on the above funding chart, there is a clear trend for the continuing support of mental health programs in Vermont. The DMH staff do not anticipate that this will change in the foreseeable future given the continuation of a healthy economic environment in the State.

Efforts to Maximize Funding

The State of Vermont is unique in its collaborative efforts to maximize mental health funding. In the area of children's mental health funding, the State receives significant allocations from the educational system and the child welfare system for the provision of services to the child/adolescent population. This blended-funding approach provides an economy-of-scale advantage for the community mental health system in a State where population numbers would ordinarily not provide sufficient funding for such a comprehensive system. This single system approach also supports a level of continuity of care in treatment that would be difficult to achieve with multiple systems.

Other efforts include data reviews and monthly financial statement reviews by DMH staff focusing on "other revenues," billing procedures, collection practices, Medicaid billings, and other fiscal issues. Results of these reviews are shared with the group of DAs and specifically with those providers that have deficiencies in any of these areas. Division staff and providers meet monthly to share information and discuss concerns and quality improvement issues. This closer oversight came about when it was discovered that some of the DAs might be heading toward financial difficulties.

Vermont's community providers are able to maximize available funding through a network of local agencies, each with an assigned geographic service area. These 10 DAs and 8 other special service agencies are able to enlarge their financial base by providing mental health services along with substance abuse and developmental disability programs. The following table reflects the combined financial impact of these agencies.

Table 4: Combined Budgets of Vermont's Community Mental Health Agencies

Program Area	FY 2003	FY 2004	FY 2005
Adult Mental Health	$36,367,639	$38,182,888	$40,206,219
Children's Mental Health	58,708,581	67,586,293	74,246,775
Emergency Mental Health	2,563,200	3,056,681	3,041,724
Total Mental Health	**97,639,420**	**108,825,862**	**117,494,718**
Substance Abuse	7,145,089	8,042,320	8,103,292
Developmental Disability	90,652,818	86,791,612	101,872,535
Other	5,104,839	1,962,044	1,935,007
Totals	**$200,542,166**	**$205,621,838**	**$229,405,552**

Source: Financial reports generated by the Vermont DMH.

Contracts and Grants Management

Data Management

Business Office staff have confidence in the current data system to provide them with the information they need to manage the system's financial operations. The data management system provides monthly expenditure and revenue reports and can also be accessed at any time for specific inquiries or ad hoc reports. Financial data can be combined with service data to analyze provider productivity and to confirm compliance with grant/contract requirements. Data from the two systems can also be used to determine unit costs or case rates. Provider agency data are also available to the Business Office and the DMH Research and Statistics Office for the purpose of tracking client outcomes. The current service delivery system does not require authorizations for services such as in a managed-care system; however, staff believe that the system could be modified to do so if this becomes a requirement.

The data systems for financial information and service data are separate systems, but Business Office staff and provider agency management personnel are able to combine information from both systems for analysis of staff productivity and program effectiveness and for the evaluation of agency outcome measures. Provider agency data systems are more integrated, with the capability for billing Medicaid services and producing programmatic service data.

Distribution of Funds to Provider Agencies

No Federal MHBG funds are awarded to for-profit entities in Vermont. The DMH program staff determine Federal and State funding allocations to provider agencies based on a historical pattern modified by contingencies relevant to the current budget period. Block Grant funds are used for emergency mental health services, CRT, and services for children with SED. Allocations may be adjusted based on agency performance data and budget increases or reductions. Individual agency allocations have not varied considerably due to consistency of funding.

State General Revenue funding is allocated to provider agencies based on each agency's size in proportion to the total DA system. Agencies work together in a "systems" approach to legislative funding through participation in the annual budgeting process. State funding has also remained consistent with some cost-of-living increases.

The DMH staff do not anticipate any issues that might have a major impact on future budgets. The Vermont Mental Health Futures initiative involving VSH and the Global Commitment initiative involving Medicaid are not likely to have a major impact on community agency budgets.

Forms of Awards to Providers

In the past, the State used contracts for funding community services but has recently changed to a grant concept (FY 2005). Currently, the DMH uses grants for specific services to specific client populations in funding the 10 DAs and other smaller provider agencies. Funds are provided to the agencies in quarterly installments with reconciliation of monthly service data to ensure that the correct services are provided to the appropriate client populations. Allocations to different service areas or to different agencies (if warranted) can occur during the operating year when service data indicate this is necessary.

The contracts previously used by DMH and the grant format currently being used identify the amount of Federal Block Grant funds in each contract as well as the Catalog of Federal Domestic Assistance (CFDA) number (93.958). There is a clear accounting trail for Federal Block Grant funds in Vermont's mental health grants/contracts. Provider agency annual audits are required to note each agency's expenditure of Federal Block Grant funds by CFDA number in accordance with Office of Management and Budget (OMB) Circular A-133.

Fiscal Oversight, Monitoring, and Audits of Provider Agencies

The Vermont DMH has a close oversight-role relationship with its providers. The Division's Business Office staff receive monthly financial reports from each provider. These reports are designed to show revenues and expenditures with current monthly figures as well as year-to-date figures and comparison to annual budget ratios. Staff also receive agency balance sheets and service reports monthly. All these reports are reviewed by DMH Business Office personnel to ensure that contract prohibitions regarding the use of Block Grant funds are met and to ensure that agencies maintain good financial health. Technical assistance is provided when required.

The Division's Business Office generally receives agency audits around November 1, reflecting the financial period (fiscal year) ending June 30 each year. An auditor supervised by the DMH Financial Administrator reviews the audits for compliance with OMB Circular A-133 and State requirements. If issues are noted, the audit is forwarded to the Mental Health Financial Administrator for a second review, with a memo to the provider agency noting the issue. Followup is performed by the DMH Business Office in communication with the provider agency's independent audit firm. The independent auditor and provider are responsible for issuing a corrected audit report and for resolving any compliance issues noted. The audit and all related communications are maintained in the Business Office's files.

The Vermont DMH financial management system is designed to deal with audit exceptions regarding potential return of funds in such a manner as to prevent the actual return of money. If audit exceptions identify overpayments, the amounts are adjusted against future earnings for the agency in question. When exceptions are noted in the current fiscal year, contracts can be amended to transfer amounts to other service programs or to other agencies. Block Grant funds can be re-allocated within the 2-year expenditure period to ensure that they are appropriately earned and effectively utilized. The Division has not experienced the need to recoup funds as a result of audit exceptions.

In addition to regular monthly scrutiny of financial reports and service data, the DMH fiscal staff join program personnel in onsite program reviews. The Vermont system requires that all DAs pass a redesignation survey process every 4 years. This redesignation process requires a review of advance documents and onsite inspections of each agency's financial system and clinical programs. The Division's financial staff join DMH program staff in this redesignation process.

Fiscal Operations and Accountability by State Agency for Federal Grant Funds

The Vermont DMH ensures accountability for Federal funds throughout its community mental health system through its contracts/grants and required agency audits. Federal funds are drawn down on a quarterly basis by accounting staff within the Agency of Human Services (AHS). Staff within this umbrella State entity are knowledgeable regarding the Federal Cash Management Act and ensure compliance with the provisions of this Act. Quarterly draws are based on a flat amount adjusted by the level of eligible expenditures reported for the quarter in DMH accounting reports.

The State utilizes blended funding in financing community mental health services and ensures appropriate identification of various funding sources through its accounting codes and the CFDA number related to each Federal funding source. Block Grant amounts and CFDA numbers are listed in each grant/contract with community agencies, and funding sources are identified in the remittance advice accompanying payments for services to these agencies. The accounting code for Block Grant payments (Code 42530) is included in remittance advices, which include Block Grant funding. Annual agency audit reports are reviewed to ensure reconciliation to these payments.

The Community Mental Health Services Block Grant Expenditures

A review of Federal Block Grant award notices and Block Grant Expenditure Reports matched against DMH accounting records confirms that Vermont appropriately earned its Block Grant allotment for FY 2004 and FY 2005. Federal Block Grant expenditures were incurred and paid within the 2-year period of the grant award.

The State of Vermont operates on a July to June fiscal year basis. According to its financial policies, all funds are obligated when contracts, grants, or purchase orders are approved. The State fiscal year closes on June 30, and obligations incurred by that date must be paid and expensed by September 30 of the same calendar year to be accounted for as an expense for the fiscal year ended on June 30. Any obligations not paid by the September 30 deadline are referred to the fiscal year beginning July 1 of the current calendar year. Source documents supporting funding obligations and expenditures include contracts, grants, purchase orders, paid invoices, and service data.

Maintenance of Effort (Section 1915(b)(1)

Vermont calculates its maintenance of effort (MOE) requirement for a given year by computing an average of actual eligible expenditures for the 2 previous years. Expense elements considered eligible expenditures must be consistent from year to year. Eligible expenditures were verified by examining DMH financial records, summary reports, source documents, provider contracts and grants, and audit reports showing program expenditures and revenue sources from which said expenditures were paid. The following table indicates that Vermont met its MOE requirements for FY 2005.

Table 5: MOE Requirements and Expenditures

Year	Actual Expenditures	MOE Required
FY 2003	$31,177,489	
FY 2004	$31,140,152	
FY 2005	$38,200,949	$31,158,205

Children's Set-Aside (Section 1913(a))

States are required to expend not less than the base amount of funding expended in FY 1994 for an integrated system of mental health services for children with SED. The base requirement for Vermont's children's set-aside amount is $5,049,514. Vermont's current data management system does not provide specific information that identifies the number of children with SED that it serves. This factor makes it more difficult to verify the actual level of expenditures for this client population group or which of these clients were funded by State General Funds versus other Federal funding such as Medicaid. Vermont must work with the Grants management Officer to establish a consistent, documented methodology for reporting their community mental health services for SED children.

Administrative Expenditures (Section 1916(b))

Administrative expenses for the Vermont DMH have ranged from 2.8 percent to 3.6 percent over the past 5 years. As a matter of financial policy, the DMH does not allocate administrative overhead to the Federal MHBG. A review of Block Grant expenditures for direct programs and a quarterly cost allocation schedule validates that this is correct.

Annual Audit (Section 1942)

The State of Vermont contracts with an independent audit firm for a Single State Audit on an annual basis. The State Auditor's Office is responsible for obtaining the audit and performs a review of the findings to ensure compliance with OMB Circular A-133. Copies of the Single State Audit are forwarded to the Speaker of the House and the President Pro Tempore of the Senate, to the Vermont General Assembly, and to the Governor.

The most recent Single State Audit performed for Vermont covered the fiscal year ending June 30, 2005, and was received on December 29, 2005. A review of the FY 2004 and FY 2005 Single State Audits revealed that there were no audit findings related to the Vermont DMH.

Other Requirements not Covered Elsewhere

The Vermont DMH does not contract with for-profit agencies for the provision of community mental health services. Contracted providers are made aware of Block Grant compliance issues through contracts and Division policies and communications, including prohibited expenditures. Independent audits from contracted providers have not revealed any findings relative to prohibited expenditures. There is no indication that Federal funds were used to satisfy any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funds.

CHAPTER III: RURAL LOCAL PROGRAM VISIT
WASHINGTON COUNTY MENTAL HEALTH SERVICES, INC.

LOCAL SYSTEM SNAPSHOT

Program Description

Washington County Mental Health Services, Inc. (WCMHS) is a comprehensive community mental health center (CMHC). The WCMHS is one of 10 agencies designated under Vermont statute to provide a comprehensive range of services for adults with mental illness, children and adolescents with serious emotional disturbance (SED), and individuals with developmental disabilities. The WCMHS also provides outpatient and outreach services for adults and children with less-severe mental health needs. Funded primarily though a contract with the State, WCMHS is a private, nonprofit corporation with a citizen Board of Directors. Other funding is from local and State grants and contracts, private insurance, Green Mountain United Way support, contributions, and fees based on the client's ability to pay. The agency's mental health services are provided to residents of Washington County and to the towns of Orange, Washington, and Williamstown in Orange County.

The agency provides inpatient and outpatient services, case management, rehabilitation, and residential programs for adults. Individual, group, and family therapy, as well as specialized intensive programs, are provided to children and young adults and their families. The WCMHS also provides 24-hour emergency services.

Quality Improvement

The WCMHS has a history of innovation and a focus on improving the quality of its programs. The agency has a quality improvement plan that is updated annually. The WCMHS focuses its quality improvement effort on providing effective supervision of staff, with a goal of strengthening its programs. For example, all staff are trained and supervised in trauma aspects of mental health treatment.

Consumer and Family Involvement

The WCMHS has placed a priority on consumer and family involvement for over 10 years. Input is regularly sought from adult consumers and from parents and youth receiving services. The WCMHS has effective Adult and Children's Local Standing Committees that sponsor community forums to identify needs and to assist the agency in its planning process. The WCMHS administrative staff are working collaboratively with consumers and other stakeholders on identifying the role of professionals and consumers in a transformed system.

The WCMHS Board of Directors includes consumers and family members. At the time of the monitoring visit, approximately 20 consumers were working at the agency and were estimated to

provide 5 to 10 percent of WCMHS services through a contract with Vermont Psychiatric Survivors (VPS). Through this arrangement, VPS is the employer rather than WCMHS. Five to six consumers, such as the Supervisor of Peer Support Services, have transitioned to full-time, long-term positions at WCMHS. The WCMHS also contracts with VPS for a peer counselor who works in its Recovery Education Program, which uses the Mary Ellen Copland model of recovery.

A catering service run by a group of consumers at Sunrise Recovery Center provided refreshments for the local program visit. In addition, a group of consumers from Sunrise met with the Monitoring Team to discuss agency services. The Peer Education Coordinator described the community education/antistigma project that includes visits to local schools and Mental Health Awareness Day activities. Another consumer talked about her work as a volunteer at a senior citizen center, and others described how much they had been helped by WCMHS's recovery-oriented services and supports.

It was clear that the individuals with whom the Monitoring Team met feel valued and listened to and that there are a number of mechanisms within the Washington County mental health system for them to provide input and be actively involved in the areas of program monitoring, service delivery, policy development, and evaluation. One of the consumers mentioned how helpful she has found the peer-operated warm line to be and that, when she was feeling stressed, how helpful it was to be able to pick up the phone and talk to someone with the same issues and experiences that she has.

ADULT SERVICES

Coordination and Continuity

The WCMHS provides the following services to adults: inpatient and outpatient services; individual, group and couples therapy; emergency and screening services; and case management, rehabilitation, and residential programs for adults with long-term mental illness. The focus is on enhancing access by providing services in satellite offices and other settings, in addition to transportation when needed.

The WCMHS is a large agency which serves individuals residing in over a dozen cities and towns. It serves individuals of all ages with developmental disabilities and mental health and substance abuse issues, so services must be coordinated within its various program and service components, as well as with outside organizations and agencies, to assure continuity of care. For adults, Vocational Rehabilitation, Probation and Parole, and Court Diversion are some of the systems and agencies with which services are coordinated. Agency clinicians and treatment coordinators work with referral sources on a case-by-case basis, and, when appropriate, treatment teams are developed with other agencies in an effort to provide the most effective services.

The agency's Center for Counseling and Psychological Services (CCPS) provides the following services to adults: office-based psychotherapy at several locations; treatment of the effects of psychological trauma; screening and referral at CCPS and a local health center; psychiatric services; and off-site psychological services.

The Community Rehabilitation and Treatment (CRT) Program has offices in Montpelier, Barre City, and Waterbury and serves adults with SMI requiring long-term care. Its outpatient program provides comprehensive case management and counseling services to individuals with co-occurring disorders as well as to those with SMI. Community-based psychiatric rehabilitation is provided by the Rehabilitation Team, and Support Workers are on call to augment team services as needed.

Other CRT services include the Dialectical Behavioral Therapy (DBT) Program and Sunrise Recovery Center, which offers a wide range of recovery-based programs to enhance consumer connectedness to the community and to support consumers' efforts to lead self-directed lives. Green Mountain Rehabilitation Services' focus is on working with consumers seeking competitive employment to enhance their independence in the work environment.

The CRT program also provides consumers with housing options such as group homes and individual apartments. Housing supports and activities that promote social interaction, personal development, and independent living skills are integral to residential services. The goal is to facilitate and support more independence in the consumer's living situation.

Community Resources Development manages affordable, stable, community-based housing projects and also attempts to develop community understanding of mental illness by sponsoring the Gather Volunteers Program. This program works with consumers to support them in developing roles and building support in natural/community settings; it encourages family and consumer involvement in addressing such issues as service planning, advocacy, peer support, stigma, inclusion, and social integration.

In addition, WCMHS provides Intensive Care Services. Its Emergency Team covers all of Washington County and part of Orange County and is available around the clock for crisis intervention and assessment. The Team provides telephone consultation, assessment for admission to local and statewide residential crisis programs, onsite crisis intervention, referral and followup, and critical incident stress debriefing.

There is also a residential hospitalization program, Home Intervention, with onsite psychiatric, nursing, and mental health services. Although located in a residential area, it can offer one-to-one support services to individuals requiring them and can provide Home Intervention services in the consumer's home under certain circumstances.

Delivery Strategies

The CCPS operates a collaborative program with the Central Vermont Council on Aging, Lamoille County Mental Health Service, and the Clara Martin Center. Program offices are co-

located with Council on Aging staff in Washington, Lamoille, and Orange Counties. The program provides in-home psychological services to older adults in the three counties. Referrals are made by the Council on Aging as well as by the community at large.

Substance abuse services are provided to catchment-area adults by Central Vermont Substance Abuse Services (CVSAS) in collaboration with WCMHS, the Howard Center for Human Services, and the Clara Martin Center. Services include assessment; individual, couples, and group counseling; psychiatric services; and an intensive outpatient program. The WCMHS's Emergency Team offers 24-hour emergency services, and CVSAS provides direct referrals to residential treatment services.

CHILDREN'S SERVICES

The WCMHS children, youth, and family services consist of the following service components:

- Psychiatric services;
- Case management;
- Transition services, which assist youth up to 22 years old who have SED prepare for independent living, college, or other post-high-school living situations;
- The Skyline Program, an intensive treatment-based program for youth with offending behaviors;
- Jump on Board for Success (JOBS), a program that provides community-based supported-employment services for youth between the ages of 16 and 22 with emotional/behavioral disturbance;
- Intensive in-home, family-based services;
- Children's Upstream Services (CUPS)/Success by Six, which uses outreach specialists to provide clinical and consultation services with other area agencies and daycare providers;
- Therapeutic childcare services; and
- Intensive school-based services, which include:
    - Achieving Collaborative Educational Services (ACES), which works with referred children, their schools, and their families to deliver individualized services designed to prevent out-of-community placement;
    - Helping Empower Adolescents to be Responsible Teens (HEART), an adolescent day treatment program;

- The Central Vermont Collaborative for Children with Autism Spectrum Disorders; and

- Respite care services.

Coordination and Continuity

The WCMHS has piloted a number of system integration initiatives. It has two specialized Local Agency Teams. One interagency team was developed for youth with immediate treatment needs. The second team is an early childhood team. These teams are not funded, but there is a strong commitment from the agencies to support this process. The WCMHS has specialized in providing a range of school-based services, described above, all of which have a case-management component to assure continuity of care.

Delivery Strategies

The WCMHS has developed two specialized initiatives to address the changing needs of the children's system. The first initiative addresses the increasing lack of availability of therapeutic foster placements for youth. The WCMHS developed staffed foster care homes that target youth with highly intensive needs. This approach, also referred to as "microresidential," has been effective in keeping youth in the community. This program currently is receiving youth from other communities across the State. The second initiative addresses the need for staff who have specialized training in applied behavior analysis. With the State's emphasis on least-restrictive, home-based treatment and with the high turnover of clinical staff, there has been a critical need for such training. The WCMHS staff developed an applied behavior analysis curriculum at Johnson State College, which is available for staff at a reasonable cost. This curriculum is available to clinicians across Vermont via distance learning.

The WCMHS has worked to make its services accessible to youth with special needs and to minority populations. Program materials have been translated into Bosnian and Cantonese to accommodate refugee populations, and WCMHS has sponsored potlucks in local ethnic neighborhoods.

FINANCIAL MANAGEMENT

Expenditure for Mental Health Services

Vermont's community mental health system is made up of 10 designated agencies (DAs), each with a designated service area, and a specialized services agency that is a statewide resource for children's services. The DAs contract with DMH to provide specific services to specific client populations. There is a close working relationship between these agencies and DMH, with the requirement for provision of client service data and fiscal data through a statewide management information system. Monitoring and technical assistance are provided by DMH on an ongoing

basis, and agencies are evaluated every 4 years for redesignation. Some of these agencies provide community-based substance abuse services as well as mental health services.

The following table presents a financial picture of WCMHS, one of the DAs contracted to provide community mental health services to a geographic area in Central Vermont. The agency provides mental health, substance abuse, and developmental disability services for adults and children in Washington County and the towns of Orange, Washington, and Williamstown in Orange County.

Table 6: WCMHS Expenditures for FY 2003, FY 2004, and FY 2005

Category	FY 2003		FY 2004		FY 2005	
Community Mental Health		%		%		%
Adults	$6,699,619	24.4	$6,616,118	22.9	$7,119,700	21.9
Children	8,468,921	30.9	9,873,142	34.1	11,653,701	35.9
Emergency Services	310,071	1.1	355,269	1.2	486,169	1.5
Total Community MH	**15,478,611**	**56.4**	**16,844,529**	**58.2**	**19,259,570**	**59.3**
Substance Abuse	62,831	0.2	66,509	0.2	53,061	0.2
Developmental Services	11,858,371	43.2	11,949,900	41.3	12,917,660	39.8
Other	43,800	0.2	66,452	0.2	256,425	0.7
Totals	**$27,443,613**	**100.0**	**$28,927,390**	**100.0**	**$32,486,716**	**100.0**

Source: Audited annual financial statements for FY 2003, FY 2004, and FY 2005.

Notes:

1. Emergency Services Screening is available to adults and children.
2. FY 2006 financial statements were not available at the time of the review.

Table 7: WCMHS Revenues for FY 2003, FY 2004, and FY 2005

Category	FY 2003	FY 2004	FY 2005
Patient Fees	72,830	26,931	38,816
Medicaid	6,225,452	8,191,560	9,083,550
Case Management	867,589		
CRT Case Rate	5,163,462	5,466,737	5,904,237
Insurance	262,838	221,360	191,545
Waiver Services	9,933,727	10,991,155	11,806,634
Intermediate Care Facilities/Mental Retardation	662,970	(8,848)	
Room and Board	875,549	844,566	870,595
Other Services	424,238	612,828	979,327
Total Revenue from Fees	**24,488,655**	**26,346,289**	**28,874,704**
DMH Contracts/Grants	416,828	273,681	432,294
Other State Contracts/Grants	1,946,205	2,284,325	2,674,963

Category	FY 2003	FY 2004	FY 2005
Local Revenue	11,484	136,429	248,206
Other Revenues	493,854	496,083	632,766
Total	**$27,357,027**	**$29,536,807**	**$32,862,933**

Source: Source: Audited annual financial statements for FY 2003, FY 2004, and FY 2005.

Notes:

1. The agency accounts for revenues by service category within program areas providing additional details relative to State contracts and grants, Federal grants, client fees, and Medicaid receipts via individual schedules within the audited financial report.

2. Terminology for some funding sources changes over the years as the same client populations are served within the general categories of funding.

Funding and Expenditure Trends Over the Past 3 Years

Services for children and adolescents are increasing at a faster rate than are services for adults, with children's mental health expenditures increasing by slightly over 37 percent from FY 2003 to FY 2005 while adult mental health services increased by a little more than 6 percent over that same period. Expenditures for developmental services increased by almost 9 percent, with overall agency expenditures increasing by over 18 percent (18.4 percent).

It is more difficult to measure trends in revenues due to changing funding sources; however, it is evident that the agency continues to rely heavily on State and Federal revenues. Patient fee revenue has dropped almost 47 percent over the past 3 years, while Medicaid revenues have increased by almost 46 percent. Insurance revenues have dropped by about 27 percent; however, local support has increased by over 200 percent. The most positive trend in WCMHS's financial situation is its continuing growth and stability in view of some earlier financial difficulties.

The agency's FY 2005 independent audit report cited agency staff for several areas of strength. It was noted that the agency's accounts receivable days were the second lowest in the State and the aging of accounts is among the best in the State. The agency was also recognized for having personnel costs and occupancy costs significantly lower than the State average for similar operations.

The Community Mental Health Services Block Grant Expenditures

The Vermont DMH grant/contract with WCMHS for FY 2005 provided a total of $36,573 in mental health block grant funding for services for children and adults. A total of $31,573 was provided for respite services for children with SED, and $5,000 was provided for emergency services. The agency's audited financial statement for FY 2005 listed total Federal Community Mental Health Block Grant (MHBG) (Catalog of Federal Domestic Assistance (CFDA) # 95.958) expenditures of $63,700.

The agency communicates its use of Federal MHBG funding through its annual budgeting process and through regular reports to its Board and staff. The Board of Directors reviews and approves the agency's annual budget in a public meeting format beginning in December each year. Exhibit B of the DMH grant/contract, containing the Federal Block Grant amount, is shared with agency staff along with monthly financial reports. The annual audit also identifies the agency's Federal Block Grant funding by type.

There is clear identification of the Federal Block Grant CFDA number and grant amount in the DMH contract/grant document, with accountability of these funds tracked through monthly invoices and finally in the agency's annual audit. Vermont's identification of this information is clear and precise

CHAPTER IV: SUMMARY AND RECOMMENDATIONS

AREAS OF STRENGTH

Best Practices (State)

Vermont's 2005 Mental Health Block Grant Application (page 20) includes the goal of "orienting the mental health system to use more scientific rigor in assessing the efficacy of services and supports." Consistent with that goal, Vermont provides the following evidence-based practices (EBPs) to adults: Assertive Community Treatment (ACT), Family Psychoeducation, Illness Management and Recovery, Integrated Dual Diagnosis Treatment (IDDT), and Supported Employment (SE). For example, Vermont's high fidelity-rated SE services target CRT consumers, Vermont's adults with the most serious mental illness (SMI). During State Fiscal Year (SFY) 2005, wages were reported to the Vermont Department of Employment and Training for 850 to 900 CRT consumers, which was 25 to 30 percent of all individuals served in CRT programs. Dialectical Behavioral Therapy (DBT) has also been implemented in all parts of the State. The availability of 5 of the 6 recognized adult EBPs in the State's 10 catchment areas and the consistent and deliberate way that they have been deployed is noteworthy.

Vermont has demonstrated the effectiveness of respite services, therapeutic foster care, and therapeutic family case management in Children's Services.

Exemplary Efforts (State)

Vermont Psychiatric Survivors (VPS) is the statewide consumer/ex-patient organization. The Division of Mental Health (DMH) allocates a significant amount of State, Mental Health Block Grant (MHBG), and Real Choice Grant funding to contract with VPS to solicit input from consumers regarding policies and services and to enhance the role of consumers in areas such as policy development, service delivery, and education and training of consumers and other mental health system stakeholders. The VPS also collaborates with and assists community mental health centers (CMHCs) throughout the State in promoting the development of new consumer/ex-patient self-help support groups and consumer-operated services, with the goal of establishing and maintaining at least one local support group in each catchment area. In addition, the State and Local Adult Program Standing Committees (mandated by Vermont's "Administrative Rules On Agency Designation") and the vital role that these committees play on the State Mental Health Planning Council (MHPC) promote and ensure consumer and family input at all levels of the system of care. The respectful partnership that DMH has forged with VPS, the Standing Committees, and other consumers and family members is exemplary of the role that consumers and families can play in a transformed mental health system and one that should be shared with other States.

One of the Vermont mental health system's major strengths is its consistent and ongoing efforts to enhance and refine the quality and effectiveness of the service system. Examples of these

efforts include the work of the Clinical Practices Advisory Panel, which has been instrumental in the development and implementation of EBPs throughout the State, and the Vermont Mental Health Performance Indicator Project. Other examples of these efforts are the comprehensive, broad-based and transparent Vermont Mental Health Futures Project planning process and the strategic manner in which the State's compliance monitoring and quality improvement processes have been used to address the quality and appropriateness of care and to provide system leadership and oversight. At the time of the monitoring visit, the Community Links pilot project was being developed to train consumers to be peer support specialists and work one-on-one with consumers who have been the most challenging to engage and either have contacts exclusively with providers or with no one at all when discharged to the community. These individuals are high-end users of services that Vermont and other States have typically been unsuccessful in engaging in other peer support and recovery efforts. The facts that consumers will provide the service and that Vermont has a good record for using outcome data and lessons learned earlier to strengthen and enhance new service development speak well for the success of the project.

It is noteworthy that the key legislation governing children's mental health services in Vermont was written 18 years ago. This forward-looking legislation, Act 264, has guided the systems-of-care development and created a framework for family involvement and system planning. The fact that this legislation has been effective for almost 2 decades speaks to the degree of consistency and commitment that DMH and its partners have had to a family-centered, flexible approach in the State. In this regard, it is significant that only two children's services directors have served during this period.

The DMH and other system stakeholders have sought various means of support in addition to Federal grants to improve the service system. Partnering agencies have also been willing to share their resources in innovative ways, trackin the funds to assure that categorical funding requirements are met.

The DMH is supportive of meaningful family involvement. The consistent support of the Vermont Federation of Families for Children's Mental Health has created a network of family support. The Peer Navigators funded in this partnership are effective.

Consolidation of financial operations for DMH within the VDH has provided benefits in operational efficiencies through shared fiscal systems and other infrastructure. The level of collaboration and communications between DMH and community providers is exceptional, as is the Division's relationship with the State Medicaid office. The DMH staff within the VDH's Business Office provide a close level of monitoring and technical assistance to community providers, ensuring a systematic approach to common issues.

Funding for children's mental health services in Vermont significantly benefits funding partnerships with the State's educational system and child welfare system. Vermont officials have transcended territorial boundaries regarding their individual programs to ensure that Vermont children receive a higher and better-coordinated array of community mental health services.

Best Practices (Local)

Washington County Mental Health Services, Inc. (WCMHS) has been a partner with DMH in demonstrating the effectiveness of its respite, therapeutic foster care, and therapeutic family case management services. The WCMHS also provides DBT.

Exemplary Efforts (Local)

The WCMHS' services to adults are an area of strength. Services are comprehensive, community based, and recovery oriented. Many are provided collaboratively with other agencies and with other WCMHS programs and service components. The focus is consistently on enhancing access by providing services in homes, satellite offices, and other settings during non-office hours and by providing transportation and other supports to enhance service access and availability.

The WCMHS has a strong commitment to the principles of the State's family-centered Act 264 legislation. Children's staff have shown leadership in developing partnerships with other child-serving agencies and in creating effective blended-funding mechanisms that support integrated services.

From the fiscal perspective, WCMHS is to be commended for its strong recovery from a relatively weak financial position in Fiscal Year (FY) 2003. At that time and into FY 2004, the agency had a seriously low cashflow situation and a current ratio of 1.25:1. The agency had to rely on a line of credit as a safety net. In FY 2005, however, the agency's cashflow significantly improved, eliminating the need for a line of credit, and the current ratio improved to 1.6:1. Agency net assets have improved by almost 62 percent since FY 2003. The FY 05 independent audit underscores these improvements.

Agency staff credit improved internal controls and dynamic leadership with this fiscal turnaround. Improved communications with and participation by senior management in key decisionmaking is seen as the most important ingredient in this success. Staff also are pleased with an improved management information system (MIS) which allows them to analyze fiscal operations and program services for efficiencies and effectiveness. The WCMHS is one of the five DAs that have purchased the new MIS endorsed by DMH for community centers. The MIS produces an excellent array of regular and ad hoc reports for evaluating agency operations and financial trends.

OPPORTUNITIES TO ENHANCE AND IMPROVE THE SYSTEM

Issues that Need to be Addressed (State)

There has not been ongoing active collaboration and partnering with the substance abuse system in the development and implementation of IDDT. Given that 6 of the 10 designated agencies

(DAs) contract to provide substance abuse as well as mental health services, the lack of collaboration is a missed opportunity to provide seamless, integrated services for individuals with co-occurring disorders. Based on discussions with staff onsite, DMH's move to the VDH, where Alcohol and Substance Abuse Services are located, and the new Co-occurring State Incentive Grant (COSIG) will provide both opportunities and resources for collaborating and partnering. These developments may also offer financial advantages for the two systems and DAs if they are able to use their combined resources to leverage additional funding and increase and enhance service capacity.

It was also unclear to what extent services for individuals with co-occurring disorders target older adults. Unless this population is specifically targeted and outreach strategies developed to connect older adults with mental illness who also have alcohol and substance abuse issues to needed services, they are at risk of being overlooked and underserved. As Vermont transforms its mental health system, the need for a lifespan approach to service delivery should be emphasized.

Two issues present a challenge to the children's mental health system. These are the recent reorganization and the Global Commitment to Health (GCH). There has not been sufficient time to evaluate the effects of the reorganization. There are concerns about whether a chronic disease model will be effective as an approach to treating mental illness. Some aspects of the reorganization have been positive. These aspects include the New Agency Team and the training being given to staff and contractors of the Agency of Human Services (AHS). The GCH is likewise too new an initiative to determine its outcome. There is concern about whether youth with intensive needs will continue to receive the level of services currently provided under the GCH funding caps.

There is some concern that the adult and children's systems may become less coordinated. Some parents believe there needs to be greater consistency across local systems. Flexibility in local systems of care may further these perceived differences. This variability is not as pronounced in the adult system. The DMH should consider exploring ways to bring stakeholders in the adult and children's systems together for cross-system planning. One common issue that could be addressed in this way is to plan for services for transitional-aged youth.

The documented staff turnover rate at CMHCs is a clear challenge. The DMH and other stakeholders are demonstrating leadership and commitment to addressing this issue, however. The approach taken by WCMHS (described below) is promising. The DMH clearly wants to keep the current vision alive and to maintain the leadership and principles of the systems of care.

The current mental health delivery system in Vermont makes it difficult to identify recommendation for improving that system. The significant funding partnerships between DMH and the State's educational system and child welfare system do present a special challenge for system administrators. As citizens become more aware of the ratio of children's mental health funding to adult mental health funding (adults 37.5 percent and children 45.1 percent), given the comparative size of the two populations (adults 72 percent and children 22 percent), challenges may surface that focus on a more proportionate allocation of State funding. Such challenges

might be avoided through improved communications as to the sources of children's mental health funding. The funding partnerships described above cause the size of the children's mental health allocation to appear disproportionate, unless it is known that children who would otherwise be served within the budgets of the educational system and child welfare system are being served through the DMH budget. This is a unique funding partnership that is commendable and likely facilitates a better-coordinated and more-efficient service delivery system for Vermont children. Such challenges might be prevented with better communication to Vermont citizens and program advocates regarding these funding sources and unique funding partnerships. Financial reports could list the amount of funds transferred from each of the funding partners, and program service data could focus on the increased level of children served who might otherwise be served by the individual funding partners.

State mental health programs supported by State mental health funding generally focus on services for children diagnosed with serious emotional disturbance (SED) and Federal Mental Health Block Grant funds, used for children's services, are restricted to this population as well. Given these factors, it is necessary that Vermont's clinical services data system implement modifications to capture the level of services and funding related to the Children's SED population. Vermont must work with the Grants Management Officer to establish a consistent, documented methodology for reporting their community mental health services for SED children.

Technical Assistance (State)

No technical assistance needs were identified.

Issues That Need to be Addressed (Local)

The WCMHS is working to improve its services and agency management. It has accomplished a great deal already in this arena. Improving the collection of service data to better identify services for children with SED presents an opportunity to enhance the agency's own service delivery system and can contribute to this initiative at the State level as well. Support for the blended-funding approach for community mental health services for Vermont's children could be enhanced by additional focus on this core client population.

Technical Assistance (Local)

No technical assistance needs were identified.

CONCLUSION

Vermont's DMH continues to be proactive in its efforts to address the needs of individuals with mental illness. The Division's staff seek opportunities to improve the mental health system, utilizing innovative funding and partnership strategies. Division staff and other stakeholders are attempting to capitalize on the merger with the VDH. The children's system is making further

progress toward the development of local systems of care and in seeking ways to improve family involvement. The adult system is increasingly incorporating evidence-based best practices and is integrating vocational and housing options. Stakeholders, including consumers and families, are engaged with DMH in addressing challenges, such as high turnover of provider staff and the capitated funding requirements of GCH.

The CMHS Monitoring Team and the CMHS Federal Project Officer (FPO) want to thank the staff of DMH, VDH, and WCMHS as well as other stakeholders who participated in this visit. The team and FPO appreciate all of these individuals for taking time out of their busy schedules to meet and interact with the team.